LESUEUR COUNTY DEPARTMENT OF HUMAN SERVICES
DOCUMENTATION OF MEDICAL APPOINTMENT

Date _____

I do hereby certify that _____ was brought in for a Medical
(Patient's Name)

Assistance (MA) covered health service by _____
(name of special transportation provider)

Time Arrived _____ Time Departed _____

_____ _____
Signature Name/Title of person signing form

_____
Name of provider entity providing the MA covered service (e.g., ABC Physical Therapy Co.)

Do not use this form for Day Training & Habilitation (DT&H) Services

HIPAA Statement: A covered entity may disclose protected health information to another covered entity or a health care provider (including providers not covered by the privacy rule) for the payment activities of the entity that receives the information. Example: A hospital emergency department may give a patient's payment information to an ambulance service provider that transported the patient to the hospital in order for the ambulance provider to bill for it's treatment services.

Note: This form must be completed in its entirety. This information is subject to audit by representatives of the Minnesota Department of Human Services (DHS), the Federal Office of Inspector General (OIG), and the Federal Centers for Medicare and Medical Services (CMS).

Special Transportation Provider: Maintain a copy of this signed form in the patients file for 5 years.